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Today's Agenda

Welcome and introductions

Standard framework of integrated care

Tools and resources to assist in defining long-term vision for integrated care

In-depth understanding of the PIPBHC evaluation and continuous quality improvement requirements

Technical assistance offered by CIHS

SAMHSA-HRSA
CENTER for INTEGRATED HEALTH SOLUTIONS

Best Practices for Implementing Integrated Services

Presented by:
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Integration Senior Consultant

SAMHSA HRSA

integration.samhsa.gov

Learning Objectives for This Module

Participants will learn the continuum of integrated care (coordinated, co-located, to more fully integrated) and best practices for implementing integrated services

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Defining Our Terms

- How we define a “Term” determines how we structure beliefs and ultimately our behavior
- Terms are at the core of how we think and act
- Importantly, if policy makers, clinicians &/or administrators are not clear on the definition and source of their terms it is difficult to design or implement an integrated health model

Integration Terms

Some Integrated Health Term Sources:

Research Literature - ”Collaborative Care”

Policy - “Health Home”

Accrediting Bodies - “Patient Centered Medical Home”

Provider Agencies - “Patient Centered Healthcare Home”

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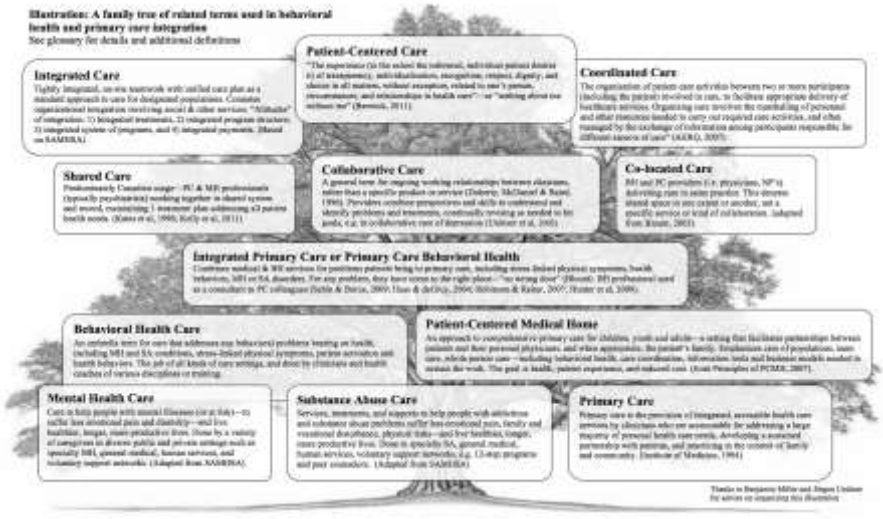

From: Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf

Defining Integrated Health

"At the simplest level, integrated behavioral & physical health care occurs when mental health specialty & primary care providers work together to address the physical & behavioral health needs of their patients."

"Integration can be bi-directional: either (1) specialty behavioral health care introduced into primary care settings, or (2) primary health care introduced into specialty behavioral health settings."

Source: Butler M, Kane RL, McAlpine D, Kathol, RG, Fu SS, Hagedorn H, Wilt TJ. Integration of Mental Health/Substance Abuse and Primary Care No. 173 (Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-02-0009.) AHRQ Publication No. 09- E003. Rockville, MD. Agency for Healthcare Research and Quality. October 2008.

Defining Integrated Health

A practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Source: Peek CJ. The National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus [AHRQ Publication No. 13-IP001-EF] Rockville, MD: Agency for Healthcare Research and Quality; 2013.

Standard Framework for Integration

Referral		Co-Located		Integrated	
Key Element: Communication		**Key Element: Physical Proximity**		**Key Element: Practice Change**	
Level 1 *Minimal Collaboration*	**Level 2** *Basic Collaboration at a Distance*	**Level 3** *Basic Collaboration On-Site*	**Level 4** *Close Collaboration On-Site with Some System Integration*	**Level 5** *Close Collaboration Approaching an Integrated Practice*	**Level 6** *Full Collaboration in a Transformed/ Merged Integrated Practice*
Behavioral health, primary care and other healthcare providers work:					
In separate facilities.	**In separate facilities.**	**In same facility not same offices/clinic (e.g., separate waiting areas).**	**In same space within the same facility but separate work flows/teams.**	**In same space within the same facility regular teaming & cross staffing.**	**In same space within the same facility, sharing all practice space (one clinic/one team).**

IH Core Elements

Core Element	Details	Application/Evidence
Intentional choice of level of integration	See A standard Framework for Levels of Integrated Healthcare and Update Throughout the Document	The program has made intentional choice to coordinate, co-locate or integrate based on the available resources in the community and at whatever level it has practices in place to decrease patient burden, support active outreach, engagement and follow-up.
Team based care	There is clear identification of team members (virtual or on site)	Practices in place to support team communication, coordination and functioning, team roles, and interdisciplinary planning
Evidence based clinical models	Must fit the need of a practice setting (collaborative care, IMPACT etc.)	The practice chooses an approach that fits their setting (i.e. IMPACT, collaborative care, behavioral health consultant model) and educates staff in brief, evidence based interventions like motivational interviewing, problem solving therapy, behavioral activation etc.
Data driven systems	Practices in place that focus on population health and universal screening (with appropriate clinical exceptions).	Established workflows for patient identification through screening and clinical pathways in place to guide intervention and planning Outcomes and quality measures are defined, tracked, reported and used to modify care. The question is, are people getting better, is addressed through data and the practice focuses on treat to target. Registries on patients are maintained and staff are accountable for their work and patient improvement.

IH Core Elements

Core Element	Details	Application/Evidence
Clear leadership	Clear leadership toward a transformed delivery system that sees behavioral health not as an add on but as a key element of health care.	Articulates a clear vision from the top down and the bottom up on how to improve patient care, develops policy and procedures supporting IBH, performance management strategies that focus on IBH. Tackle barriers with creativity that leads adaptation of practices to support integrated care.
Stepped care	Stepped care is a system of delivering and monitoring treatments so that the most effective, yet least resource intensive, treatment is delivered to patients first; only 'stepping up' to intensive/specialist services as clinically required.	Primary care is the clinical home, everyone in the practice is trained to manage health as a combination of physical and behavioral health, all staff "work at the top of their license", and care is provided in primary care unless referral out to specialty care is required. Providing same day access for population is part of the continuum of care. Referrals out to specialty behavioral health are made when the needs are complex and beyond the scope of integrated primary care and when the specialty service is available. When the patient is stabilized, they are returned to their primary care clinical home. During specialty care the care is coordinated with primary care.

IH Core Elements

Core Element	Details	Application/evidence
Defined continuum of care	Each practice and provider knows when to treat, when to consult, and when to refer.	Clear parameters are established for these consultation and referral. Agreements are in place with external partners for specialty care referrals and communication.
Psychiatric Consultation	Each practice has a plan for consultation with psychiatric prescribers.	Consultation may be face to face, through telehealth or through embedded psychiatric prescribers. The plan includes easy transition back to primary care for people who reach a point of stability. Practices work on developing the consultative psychiatry role where psychiatry consults with primary care providers for most patients and only sees clients directly with the most complex needs. This model grows as payment for it advances.

The Organizational Components Impacted by Adoption of IH Models

1. Staffing
2. Building Design
3. Partnerships/Contracting
4. Financing
5. Clinical Practice
6. Health Information Technology
7. Quality Assurance & Improvement
8. Marketing/Customer Service
9. Culture
10. Brand

Common Integration Needs

- Defining & communicating the IH vision
- Investigating & implementing best practices/strategies
- Designing the business model
- Finding a BH or PC partner or hiring your own BH/PC staff
- Bridging the cultural divide between PC & BH
- Developing policies, protocols & procedures
- Clarifying funding sources & maximizing profit
- Est. or strengthening networks of care partnerships
- Developing BH registries & data collection/sharing to support clinician/administrator decision making
- Conducting work flow analysis to standardize protocols to leverage time & cost
- Training staff in BH/PC interventions & team based approaches to care coordination

Factors Influencing Model Design Adoption

Many factors influence the adoption of integrated approaches including:

1. **The Organization's Vision for Care Provision**
2. **Organizational Capacity to Innovate**
3. **Funding Design**
4. **Health Information Infrastructure**— organizational & state levels
5. **Provider Network**—who does what, who gets along?
6. **Location**—State, Urban, Rural

Model Components Vary in Difficulty

- Implementing discrete/structural model components was easier than changing roles and work patterns to use them.
- For example, many practices implemented disease registries, but were unable to reconfigure work processes to use them effectively for population management.
- Same-day scheduling and e-prescribing were far easier than developing care teams and population management.

Source: Paul A. Nutting, see http://www.slideserve.com/kobe/the-patient-centered-medical-home-implications-for-health-policy-and-workforce-development

Let's Dig a Little Deeper

Integration Components:

a) Organizational Change Management

b) Creating & Maintaining Partnerships

c) Redesigning Administrative & Clinical Workflows to Facilitate Integration

Key to Integration…

- Executive Leadership & Board must have a strategic plan that clearly defines, prioritizes, communicates the need for integration.
- Without this there is confusion and a lack of (or worse misappropriated) urgency

Regional Level Context Considerations

- All Health Care is Local!
- Frontier, Rural, and Urban areas have different strengths/ opportunities when it comes to integrating care
- All providers must understand their regional market:
  - What are the health needs of their zip code level populations?
  - How many service providers are present (i.e., specialty health care, hospitals, independent physician groups, lab services, social services, and government svs-courts / police / parks rec / etc.)?
  - Who do these other providers serve?
  - Are they financially sound? Do they produce value?
  - Are they in competition or coopetition?

Creating & Maintaining Partnerships

- To partner or not to partner….that is the question!
- Conduct a Partnership Strengths/ Weaknesses/ Opportunities/ Threats (SWOT) Analysis
- Map-out your provider network to determine:
  1. Provider Specialty
  2. Location
  3. If they share your consumers
  4. Capacity to reliably capture, analyze & share data
  5. Willingness to sign a Business Associates Agreement
  6. Ability / willingness to share data and coordinate care
- Develop business plan

Creating & Maintaining Partnerships

- Be clear about what you want and know your costs and data requirements (i.e., business plan)
- Approach partners with whom most of your consumers get their care
- Start with a discussion about your potential partner's wants / needs
- Make sure everyone is clear on expectations & capacity re: consent process/confidentiality, cost, required data collection, capacity to share data & continuum of care
- Consider using an IH assessment tool to learn where each other stands
- Develop a Business Associates Agreement (BBA) and focus on care coordination

Creating & Maintaining Partnerships

- Once in a partnership make sure to have regular senior leadership discussions about progress being made / or not
- Regularly discuss budget and care coordination metrics to see if targets are being hit
- Make sure middle managers are executing a work plan that focuses on administrative workflow and clinical pathway alignment

Organization Change Management

1. Vision for the Organization (Why / What / How)
2. Use of a Change Management Technology
3. Leadership Communication Plan
4. Clear Statement of Work / Charge
5. Work Plan Goals Detailing:
    a. Action Steps
    b. Accountability
    c. Measures
    d. Timelines
    e. Resource Requirements
6. Continuous Quality Improvement to Sustain the Change

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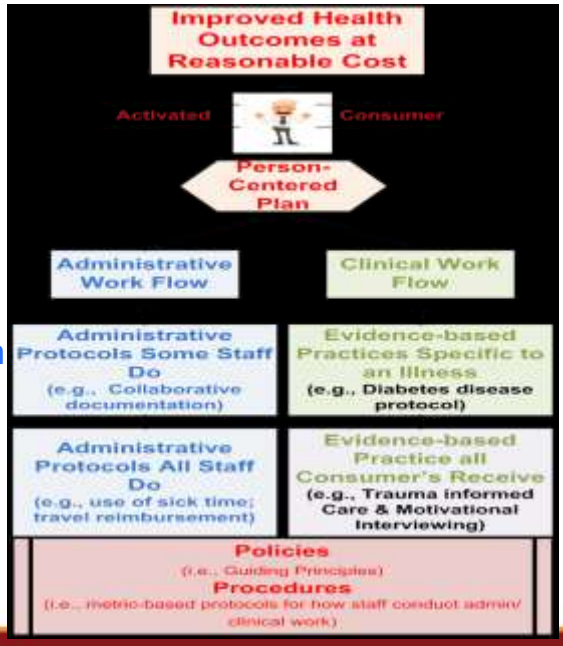
Redesigning Care Pathways: Administrative & Clinical Work to Enhance Integration to Insure Efficient & Effective Care Management & Coordination



Redesigning Administrative Workflows

Administrative Workflows Redesigns:

- Collaborative / Concurrent Documentation
- Same / Day Access & Just In Time Prescribing
- Team Based Care
- Data Sharing
- Coordination of Care
- Population Health Management
- Billing

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Redesigning Clinical Care Workflows

Clinical Workflow Redesigns:

- Adoption of Best & Evidence-based Interventions for all clients (e.g., Trauma Informed Care, Motivational Interviewing & Collaborative Documentation), for specific Diagnosis's & Social Determinant Needs
- Treat to Target Metrics for Each Condition
- Care Management Protocols for Stepped Care, Psychiatric/PC Consultation & Care Coordination

In Summary

Terms, Context, Leadership & Change Management Approaches Matter!

Integration is a multi-year system level change so the whole organization is impacted

Team-Based Resources

Bosch M, Faber MJ, Cruijsberg J, et al. Effectiveness of Patient Care Teams and the Role of Clinical Expertise and Coordination: A Literature Review. *Med Care Res Rev.* 2009. 66:5S-34S.

Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, & I. Von Kohorn. (2012). *Core principles & values of effective team-based health care*. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc. P.7.

O'Leary KJ, Wayne DB, Haviley C, Slade ME, Lee J, Williams MV. Improving Teamwork: Impact of Structured Interdisciplinary Rounds on a Medical Teaching Unit. J Gen Intern Med. 2010;25(8):826–32.

Mudge A, Laracy S, Richter K, Denaro C. Controlled Trial of Multidisciplinary Care Teams for Acutely Ill Medical Inpatients: Enhanced Multidisciplinary Care. *Intern Med J*. 2006. 36:558–63.

Smith ST, Enderby S, Bessler RA. Teamwork in Leadership and Practice-Based Management. In: McKean SC, Ross JJ, Dressler DD, Brotman DJ, Ginsberg JS, eds. *Principles and Practice of Hospital Medicine. 1st ed.* New York, NY: McGraw-Hill; 2012:860-65.

Internet Citation: Essentials Instructional Module: TeamSTEPPS® Long-Term Care Version. July 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/essentials/index.html

Change Management References/Useful Resources

- Waterman Jr., Robert H., Peters, Thomas J., and Julien R. Phillips. (1980). "Structure is not organization." *Business Horizons* 23, no. 3: 14.
- Managing Transitions: Making the Most of Change, 2nd Edition (2003). William Bridges.
- The Advantage (2012). Patrick Lencioni.
- Our Iceberg is Melting: Changing & Succeeding Under Any Conditions (2005). John P. Kotter & Holger Rathgeber.
- A Sense of Urgency (2008). John P. Kotter
- The Heart of Change (2002). John. P. Kotter
- Thinking for a Change. (2003). John C. Maxwell
- Why Some Ideas Die and Other Stick: Made to Stick. (2008). Chip & Dan Heath

Further Reading/Resources

Felt-Lisk, S. & Higgins, T. (2011). Exploring the Promise of Population Health Management Programs to Improve Health. Mathematica Policy Research Issue Brief. http://www.mathematica-mpr.com/publications/pdfs/health/PHM_brief.pdf

Parks, J., et al. (2014) Population Management in the Community Mental Health Center-based Health, Center for Integrated Health Solutions Homeshttp://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf

http://www.integration.samhsa.gov/ (Great resource on everything integration)

http://www.integratedcareresourcecenter.com/ (Website detailing what is happening with health reform in each state)

http://www.chcs.org/ (Website focused on publicly funded healthcare and the transformations underway)

http://www.h2rminutes.com/main.html (Updates on the ACA for professions—great site to sign up for email notices)

http://integrationacademy.ahrq.gov/atlas (1.Framework for understanding measurement of integrated care; 2. A list of existing measures relevant to integrated behavioral health care; & 3.Organizes measures by the framework and by user goals to facilitate selection of measures).

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Further Reading/Resources

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare; Institute for Health Technology Transformation
http://www.exerciseismedicine.org/assets/page_documents/PHM%20Roadmap%20HL.pdf

CREEPING AND LEAPING FROM PAYMENT FOR VOLUME TO PAYMENT FOR VALUE Webpage
https://www.thenationalcouncil.org/capitol-connector/2014/09/creeping-leaping-payment-volume-payment-value/

Guide http://www.thenationalcouncil.org/wp-content/uploads/2014/09/14_Creeping-and-leaping.pdf

Workbook http://www.thenationalcouncil.org/wp-content/uploads/2013/10/National-Council-Case-Rate-Tool-Kit.pdf

CMS Innovation Center: Health Care Payment Learning and Action Network
http://innovation.cms.gov/initiatives/Health-Care-Payment-Learning-and-Action-Network/

Partnering w/ Schools for MH: A Guidebook
(https://www.omh.ny.gov/omhweb/Childservice/docs/school-based-mhservices.pdf)

Further Reading/Resources

Population Management in Community Mental Health Center Health Homes – The National Council for Behavioral Health

http://www.integration.samhsa.gov/integrated-care-models/14_Population_Management_v3.pdf

AIMS Center Dashboard Templates

https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data

Cost Savings and Integrated health

http://www.baylesstherapeuticwellness.com/wp-content/uploads/2016/04/Learn-About-the-Triple-Aim.pdf

Sample Resources for States

State Level Integration Approaches/Lessons Learned:

2011 CMS Guidance for States
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=0zJCWaw_O3Q%3D&tabid=122

2013 University of Colorado State of Evidence for Integration 2013
http://farleyhealthpolicycenter.org/wp-content/uploads/2014/08/Kwan-Nease-2013-Evidence-for-integration.pdf

2014 Common Wealth Fund Guidance for States
http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/aug/1767_bachrach_state_strategies_integrating_phys_behavioral_hlt_827.pdf

2014 State Approaches to Integrating Physical and Behavioral Health Services for Medicare-Medicaid Beneficiaries: Early Insights
https://www.chcs.org/media/State_Approaches_to_Integrating_Physical_and_Behavioral_Health.pdf

2017 Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems
http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf

Minnesota Accountable Health Model: Continuum of Accountability Matrix (see: http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_181668.pdf)

Learning Objectives for This Module

- Participants will gain tools and resources to assist in defining their state's long-term vision for integrated care and planning for sustainability at the state and provider level.
- CIHS will introduce the state-level readiness assessment tool.

The "Quadruple Aim"

Population Health

Experience of Care

Per Capita Cost

Provider Satisfaction

PIPBHC- Role of the States

- ✓ Select and monitor partners (sub-grantees)
- ✓ Identify consumers most in need of integrated services
- ✓ Summarize policies that are barriers to integration and action steps
- ✓ Identify informal partnerships (e.g., community behavioral health centers, health centers, school-based health centers, substance use treatment facilities)
- ✓ Develop a report for Secretary of HHS on performance measures necessary to evaluate patient outcomes and facilitate evaluations across participating projects
- ✓ Submit sustainability report – 2nd and 4th years of grant
- ✓ Establish advisory council (that may already exist at the state level) among mental health, substance use, primary care, and children's services)

What is Our State's Vision for the Future of Integrated Care?

Planning for Long-Term Success

State Readiness Assessment for Integrated Care

An assessment tool developed by CIHS to:

1. Help gauge PIPBHC state's level of readiness to implement and sustain PIPBHC and take integrated primary care and behavioral health to statewide-scale.
2. Help identify technical assistance needs and opportunities.

Key Domains for State Level Readiness

State Capacity

- ✓ To what extent do you have a strategic plan related to integrated care?
- ✓ Who participated in the development of that plan?
- ✓ How will that plan be monitored?
- ✓ How do all relevant state agencies coordinate?
- ✓ Do you have an accurate, detailed inventory of integration efforts in your state?
- ✓ Do you have a continuous quality improvement plan in place?

Key Domains for State Level Readiness

Stakeholder Engagement

- ✓ Do you have the required advisory council for PIPBHC?
- ✓ Are the right stakeholders engaged?
- ✓ How will they play a meaningful role?
- ✓ How are you measuring consumer satisfaction?

Key Domains for State Level Readiness

Regulatory Barriers and Enabling Factors

- ✓ To what extent has your state established principles related to integration that guide rulemaking?
- ✓ Have you done an analysis of regulatory barriers? (e.g. screening requirements, billing challenges, licensing issues, data sharing challenges)
  - ✓ How were stakeholders involved in that process?
  - ✓ What are you doing to address those barriers?

Key Domains for State Level Readiness

Data Systems

- ✓ Do you have the necessary processes in place to collect all PIPBHC required data (including the adult, child/adolescent measures, SPARS, functional outcomes?)
- ✓ How will you use this data for quality improvement and planning purposes?
- ✓ What percentage of providers have EHRs?
- ✓ How does the state support information sharing?

Key Domains for State Level Readiness

Payment

- ✓ How does your state leverage value-based payment methodologies that support integrated care?
- ✓ Has your state "opened" billing codes that support integrated care?
- ✓ To what extent do you understand the total cost of integrated care?

Key Domains for State Level Readiness

Workforce

- ✓ To what extent does your state support peer-delivered care?
- ✓ What strategies is the state using to increase the behavioral health workforce "pipeline"?
- ✓ What strategies is the state using to increase the capacity and expertise of providers to deliver integrated care?

Sustainability Planning Begins NOW!

At both State and Provider Levels

Sustainability- State Level

- ✓ Demonstrate outcomes
- ✓ Measure overall cost impacts
- ✓ Pursue regulatory reform
- ✓ Build support for state level infrastructure
- ✓ Maximize policy levers
- ✓ Review payment methodologies
- ✓ Foster multi-payer commitment

Sample Resources for States

State Level Integration Approaches/Lessons Learned:
2011 CMS Guidance for States
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=0zJCWaw_O3Q%3D&tabid=122
2013 University of Colorado State of Evidence for Integration 2013
http://farleyhealthpolicycenter.org/wp-content/uploads/2014/08/Kwan-Nease-2013-Evidence-for-integration.pdf
2014 Common Wealth Fund Guidance for States
http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/aug/1767_bachrach_state_strategies_integrating_phys_behavioral_hlt_827.pdf
2014 State Approaches to Integrating Physical and Behavioral Health Services for Medicare-Medicaid Beneficiaries: Early Insights
https://www.chcs.org/media/State_Approaches_to_Integrating_Physical_and_Behavioral_Health.pdf
2017 Integrating Behavioral and Physical Health for Medicare-Medicaid Enrollees: Lessons for States Working With Managed Care Delivery Systems
http://www.integratedcareresourcecenter.com/PDFs/ICRC_Intgrt_Bhvrl_Hlth_Dual_Benis.pdf
Minnesota Accountable Health Model: Continuum of Accountability Matrix (see:
http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs16_181668.pdf)

Sustainability- Practice Level

- ✓ Know your costs
- ✓ Gauge what is and is not reimbursable
- ✓ Maximize billing
- ✓ Create efficiencies
- ✓ Prepare for value-based payment

Often Not Reimbursable…

- ✓ Up front costs
- ✓ Warm handoffs
- ✓ Huddles, staffings and collaborative care meetings
- ✓ Provider to provider consultation
- ✓ Peer Specialist (on primary care side)
- ✓ Health/Wellness Coach (on behavioral health side)
- ✓ Time spent on Continuous Quality Improvement
- ✓ Professional development/training

Maximize Billing

- ✓ Assist patients in navigating benefits acquisition
- ✓ Assess all services being delivered to determine what is – or could be- reimbursable
- ✓ Ensure staff providing services have appropriate credentials/licensures
- ✓ Use a certified coder; ensure correct codes are in the billing system; train finance staff in billing for behavioral health and care coordination
- ✓ Capture all non-billable services as well

Creating Efficiencies

- ✓ Build screening into existing workflows without devoting additional staff time to the process
- ✓ Ensure staff are working “to the top of their licensure”
- ✓ Establish productivity guidelines
- ✓ Use concurrent documentation where possible
- ✓ Reduce no shows
- ✓ Integrated behavioral health may improve primary care productivity
- ✓ Use process mapping and CQI processes

Non-Financial Aspects of Sustainability

- ✓ Reflect organizational values around integrated care in strategic plans, mission, vision, and business plans
- ✓ Promote organizational culture change through leadership, consistent messaging, staff training and capacity building
- ✓ Institutionalize integrated care through HR policies, clinical protocols and workflows, etc.

Questions?

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PIPBHC Data Requirements

Presented by:
Aaron Surma, MSW
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integration.samhsa.gov

Agenda

Individual Data Collection Requirements
- Enrollment
- Reassessment
- Discharge

Population Health Management

Available Resources

DATA COLLECTION REQUIREMENTS - ENROLLMENT

Enrollment – Overview

You will collect interview and health information from each consumer who receives PIPBHC services at enrollment (baseline) and reassessment (every 6 months).

The NOMs interview is available on the SPARS website.

Consumer Health Information (Section H)

Mechanical Indicators

- Height
- Weight
- BMI
- Waist Circumference
- Blood Pressure
- Breath CO

Blood Work

- Fasting Glucose or HbA1c
- Triglycerides
- HDL Cholesterol
- LDL Cholesterol
- Total Cholesterol

The health indicator data collection tool is available on the SPARS website

Enrollment – How to succeed

Meet your enrollment goal (goal is 100%+. <70% is a potential SAMHSA administrative review).

Create a workflow for collecting enrollment information:

- Identify who collects NOMs information & health indicators
- Protocol for scheduling NOMs interviews & health indicators
- Protocol for entering consumer-level data into SPARS

Enrollment – How to succeed (continued)

Track your performance

- Are we on track to meet our enrollment target for the year?
- Are we collecting complete information at baseline?

Enrollment – Details

- The NOMs interview must be performed within 7 days of an individual receiving PIPBHC services
- Anyone can perform a NOMs interview. No special credentials/training required
- NOMs interviews cannot be batch uploaded to SPARS
- Ask your GPO for approval to conduct NOMs interviews over the phone due to special circumstances
- The NOMs interview date is the official enrollment date

Enrollment – Details (continued)

- Mechanical indicators (BMI, waist circumference, blood pressure, breath CO) must be collected within 30 days before/after the enrollment date
- Blood labs (cholesterol panel, HgbA1c or fasting blood glucose) must be collected within 60 days before/after the enrollment date
- Health indicators that are obtained from other providers are valid as long as they were performed within the proper collection window
- Grant funds can be used to pay for labs

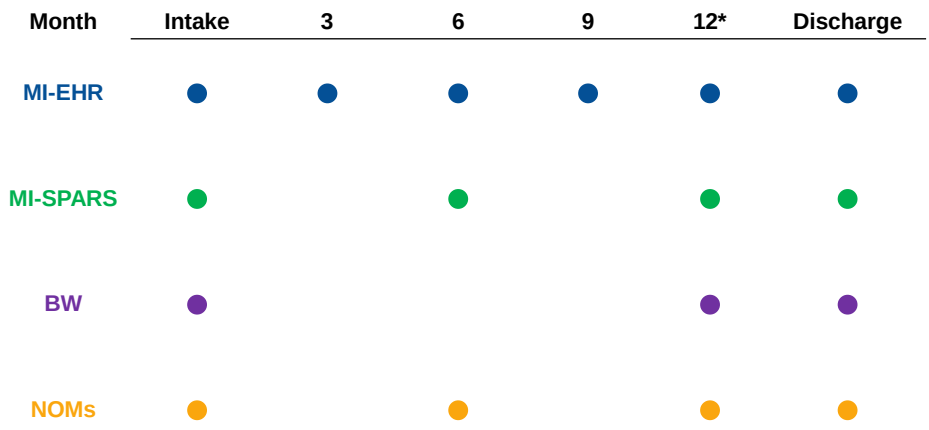
DATA COLLECTION REQUIREMENTS - REASSESSMENT

Reassessment – Overview

To track health improvement (or lack thereof) over time, you will reassess (rescreen) all enrolled consumers every 6 months.

Reassessments include NOMs interview and health indicators.

Data Collection Timeline



MI-EHR: Collect mechanical indicators; store in electronic health record
MI-SPARS: Collect mechanical indicators**; enter in SPARS**
BW: Collect blood work; store in electronic health record, **enter in SPARS**
NOMs: Conduct NOMs interview, **enter in SPARS**

* Continue same pattern until discharge

Reassessment – How to succeed

Meet your reassessment goal (goal is 80%-100%. <62% is a potential SAMHSA administrative review).

Have a process for:

- Identifying consumers who are due for reassessment
- Scheduling reassessment visits
- Entering reassessment data into SPARS

Reassessment – How to succeed (continued)

Track your progress:

- Are you reassessing everyone who is due for reassessment?
- Are you collecting all required health indicators at each reassessment?

Reassessment – Details

Reassessments are due 180, 360, 540, 720… days after the enrollment date

NOMs interview and mechanical indicators are due +/- 30 days from the reassessment due date

Blood labs are due +/- 60 days from the reassessment due date

The Notification Report in SPARS will tell you when upcoming reassessments are due

DATA COLLECTION REQUIREMENTS - DISCHARGE

Discharge – Overview

If an individual no longer receives PIPBHC services (due to moving, no longer in need of services, death, other) they should be discharged from SPARS.

Discharge – How to succeed

Set criteria for discharge. Most organizations use 90 days without contact unless it is known that the individual will not return

Set a process for discharge

- Scan your list of enrolled consumers for people who should be discharged
- Collect final NOMs and health indicators, if possible
- Create a process for entering discharge information into SPARS

Discharge – Details

Discharge from PIPBHC does not mean discharge from your organization

If you discharge someone, they can resume PIPBHC services in the future. Use the same consumer ID that you used the first time they were enrolled

South of Market Mental Health Primary Care Clinic Process Dashboard, March 2014

As of March 12, 2014

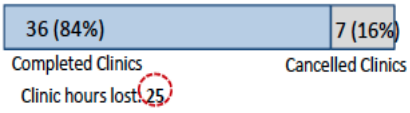
282
total clients enrolled[1]
(met grant criteria & enrolled, 8/2012-present)

67
discharged[2]

215
total active clients
(currently enrolled in grant)

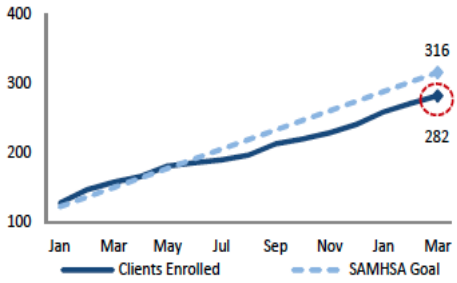
Completed vs. Cancelled Clinics

Jan 2014-Mar 2014



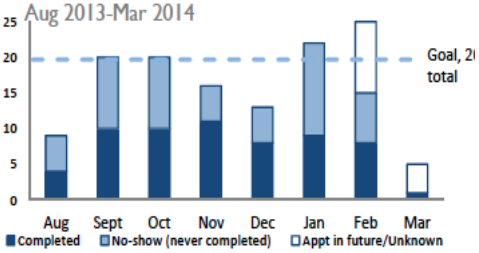
Patients enrolled vs SAMHSA Goal[3]

Jan 2013- Mar 2014



Referrals to primary care by BH providers[5]

Aug 2013-Mar 2014



TOOLS FOR POPULATION HEALTH MANAGEMENT

SAMHSA HRSA integration.samhsa.gov

Glenn County Health Care Collaborative
INDIVIDUAL WELLNESS REPORT

Name: **Bea Well**
Clinician: **John Smith**
Case Manager: **Jane Doe**

Health Care Collaborative

Normal*
Caution
At Risk

Progress on Key Health Indicators

Category	Indicator (Goal)	Baseline *August 2011*	6-Month Reassessment *February 2012*	12-Month Reassessment *July 2012*
Lungs	Breath CO (0-6)	25	8	5
Weight	BMI (18.5-24.9)	25.8	28.1	25.3
	Weight	162.0	174.0	158.0
	Waist Circumference	35.5	31.5	32.2
Blood Pressure	Systolic BP (90-140)	133	135	114
	Diastolic BP (60-90)	80	75	80
Blood Sugar	Fasting Glucose (70-99)	115	-	115
	Hemoglobin A1C (4.0-5.6)	5.4	-	5.4
Heart Health	Total Cholesterol (125-200)	197	-	189
	LDL Cholesterol (20-129)	111	-	103
	HDL Cholesterol (40+)	76	-	73
	Triglycerides (30-149)	52	-	64

Client Wellness Goal(s):

Bea Well will lose 5 pounds within 6 months.

Bea Well will maintain her excellent progress in reducing/stopping her tobacoo use.

Client Mental Health Goal(s):

Bea Well will sleep at least 7 hours each night to decrease symptoms of depression.

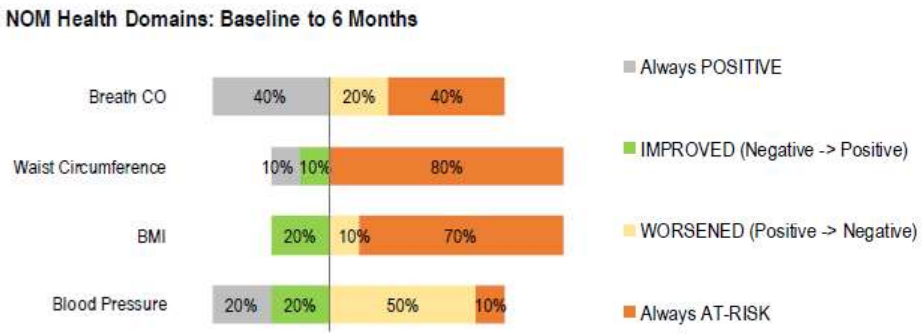
Team Huddle Report

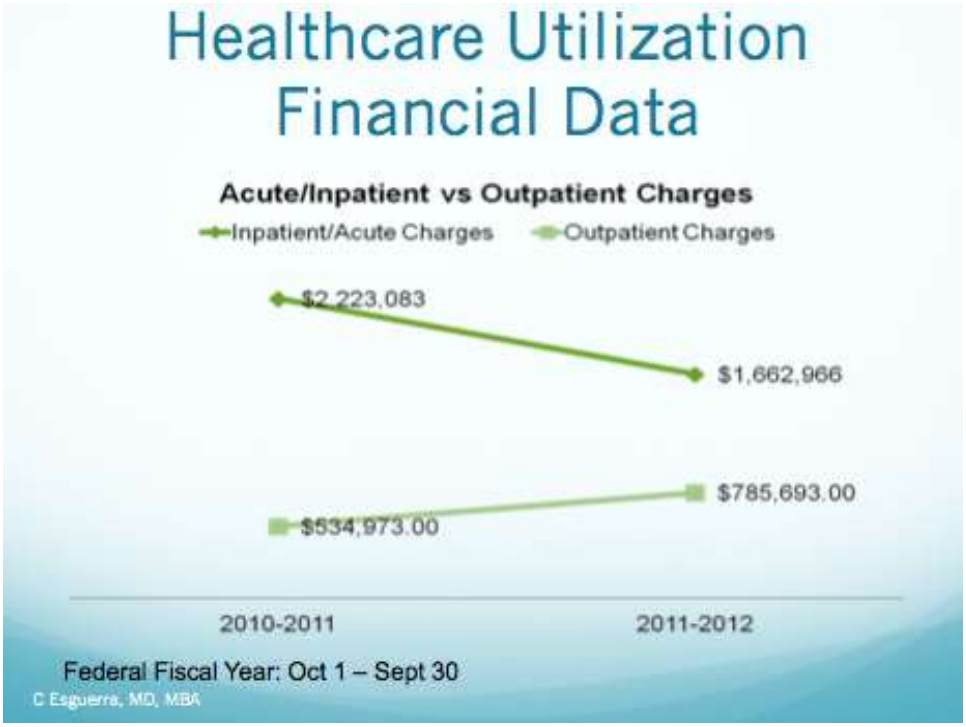
				most recent					
First Name	Last Name	Care Coordinator	Date last seen	blood pressure	breath co	BMI	risk level	Enrolled in NEW-R	Enrolled in smoking group
Bob	Marley	Carol	7/13/2016	155/100	25	32	High	Yes	Yes
Talib	Kweli	Carol	10/15/2016	145/99	30	32	High	Yes	Yes
Lauryn	Hill	Mike	6/5/2016	145/90	8	26	Med	Yes	No
Cibo	Matto	Carol	11/1/2016	130/70	5	23	Low	No	No
Poly	Styrene	Carol	11/2/2016	130/70	3	23	Low	No	No
Jason	Molina	Mike	10/29/2016	145/90	20	20	Med	Yes	No

VITALS: Percent improving/maintaining outcomes among active SAMHSA consumers

double click cell counts for consumer detail

Row Labels	Values current caseload	consumers with 2+ BMI while in	Percent maintaining/improving BMI	consumers with 2+ systolic while in program	Percent maintaining/improving systolic	consumers with 2+ diastolic while in program	Percent maintaining/improving diastolic
Care Manager 1	22	14	57%	18	56%	18	44%
Care Manager 2	24	21	52%	21	48%	21	57%
Care Manager 3	32	18	44%	20	45%	20	40%
Care Manager 4	13	10	40%	10	70%	10	70%
Care Manager 5	5	4	25%	4	75%	4	75%
Care Manager 6	28	19	58%	19	42%	19	63%
Grand Total	124	86	50%	92	51%	92	54%

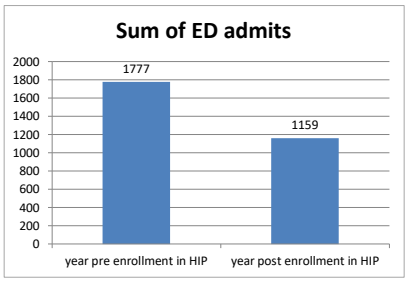

NOM Health Domains: Baseline to 6 Months
Breath CO
Waist Circumference
BMI
Blood Pressure
40%
20%
40%
10%
10%
80%
20%
10%
70%
20%
20%
50%
10%
Always POSITIVE
IMPROVED (Negative -> Positive)
WORSENED (Positive -> Negative)
Always AT-RISK

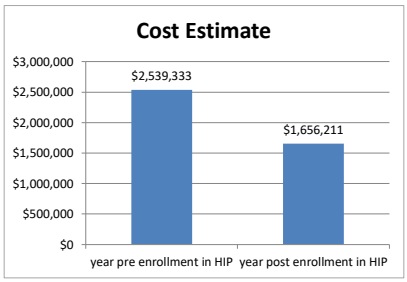

Healthcare Utilization
Financial Data
Acute/Inpatient vs Outpatient Charges
Inpatient/Acute Charges
Outpatient Charges
$2,223,083
$1,662,966
$785,693.00
$534,973.00
2010-2011
2011-2012
Federal Fiscal Year: Oct 1 – Sept 30
C Esguerra, MD, MBA

Health Integration Project

Hospital Usage

- ED admits
  - 342 consumers
  - 618 less ED admits in year post HIP enrollment
  - Average of $1429 per admit
  - Estimated annual savings $883,122





Registry Options

SPSS & Access registry examples are available on the CIHS website.

RESOURCES AVAILABLE TO YOU

Resources

CIHS - Aaron Surma, AaronS@thenationalcouncil.org and/or your CIHS liaison

GPO - Your SAMHSA grant project officer

SPARS - SPARS helpdesk, SPARS-Support@RTI.org

Other Grantees – listserv, evaluation affinity group calls (December 5!), in-person meeting

Questions?

SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Technical Assistance Offered by CIHS

SAMHSA HRSA integration.samhsa.gov

Contact Information

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